AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorization receiving this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ **Date of Birth:** _____

Health Care Provider Providing Information: _____

Address of Health Care Provider: _____

_____

Office Number: _____ Fax Number: _____

Doctor Receiving Information: Dr. Edred Shen,

Address: 2253 South Ave, Suite 3

Scotch Plains, N.J. 07076

Office Number: (908) 654- 1500 Fax Number: (908) 654 - 7391

Health Information Requested : _____

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initial: _____ HIV/AIDS testing, testing results, treatment and related information including high risk behavior documented.

Initial: _____ Drug and/or alcohol diagnosis, treatment, test results and reports, and referral information.

Initial: _____ Mental Health treatment information, test results and reports, including psychological and psychiatric studies, reports, evaluations, and referral information.

Initial: _____ Venereal Disease Information

Purpose of Disclosure: _____
This authorization is not for marketing purposes

You must read and initial the following statements:

Initial: _____ I understand this authorization will expire on termination of the Physician/Patient Relationship

Initial: _____ I understand that I may revoke this authorization at any time by notifying the organization providing information in writing, but if I do, it will not have any effect on any actions the organization providing the information took before they received the revocation.

_____ _____
Signature Of Patient or Representative Date

_____
Relationship To Patient